|  |  |
| --- | --- |
| Name:  |  |
| 1. *Designation (working/professional title):*
 |
|  |
| 1. *Formal education:*
 |
|  |
| 1. *Training/education/specialization for working with children with CIs:*
 |
|  |
| 1. *Where do you work? (Please check all that apply.)*
 |
| * Clinic/hospital
* Preschool/Kindergarten
* School
* Mainstream
* Special school
* School with integration program
* Private practice
* Centre for special needs/education
* Other……………………………………………
 |
| 1. *Age of patients you work with: (Please check all that apply.)*
 |
| * Under 3 years old
* 3-5 years old
* School children (6-12)
* Teenagers (13-18)
* Adults (19 and older)
* All of the above
 |
| 1. *Experience working with patients with CIs:*
 |
| 1. What phase of the implantation process are you involved in? (Please check all that apply.)
* 2-5 years post implant
* Other…………………………
 |
| * Pre-implant
* 1st year post implant
* 2 years post implant
 |
| 1. How many years have you worked with children with CIs?
 |
| * Less than 1 year
* 2-5 years
* More than 5 years
 |
| 1. How many patients with hearing loss (on average) do you treat?
 |
| * Total #: ……………………………………… per week……………………per year
* With cochlear implants: ……………… per week……………………per year
* With hearing aids: …………… ……….. per week……………………per year
* Other: ……………………………………….. per week……………………per year
 |
| 1. *Do parents participate actively in the therapy sessions?*
 |
| * Yes
* No
 |
|  |
| 1. *Regarding therapy with children with CIs, what do you consider your greatest challenges and/or weaknesses? What topics would you like to have addressed in a workshop? In what areas do you wish for more expertise and training?*
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|  |
| 1. *Comments/additional information:*
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|  |
| *Thank you!*And I look forward to seeing you in October! |
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